Medical Records Standards

A. Accessibility and Availability of Medical Records.

1. The Contractor shall include provisions in contracts with Subcontractors for expectations about the confidentiality of enrollee information and records and appropriate access to the behavioral health medical records of its Enrollees for purposes of quality reviews conducted by the federal Secretary of Health and Human Services, State agencies, or any agents thereof.

2. The Contractor will ensure that appropriate medical records will be available to its providers at each encounter with appropriate confidentiality measures and procedures used in the release of information.

B. Recordkeeping. Medical records may be on paper or electronic. Specific clinical documentation must be maintained electronically for reporting to the State. The Contractor takes steps to promote maintenance of medical records in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review as follows:

Medical Record Standards: The Contractor sets standards for medical records. The records reflect all aspects of patient care, including ancillary services. These standards shall, at a minimum, include requirements for:

a. Client identification information. Each page or electronic file in the record contains the patient's name or patient ID number.

b. Personal/biographical data, including: age, sex, race, address, employer, home and work telephone numbers.

c. All entries are dated and author identified.

d. The record is legible to someone other than the writer. Any record judged illegible by one record reviewer should be evaluated by a second reviewer.

e. Allergies. Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies – NKA) is noted in an easily recognizable location.

f. Diagnostic Information/tests.

g. Medication Information (includes medication information/ instruction to Enrollees).

h. Identification of Current Problems. Current mental health, chemical dependency, medical, and social problems.

i. Enrollee is provided basic teaching/instructions regarding behavioral health conditions and medications prescribed (if applicable).

j. Smoking/Alcohol/Substance Abuse. Documentation of cigarettes and alcohol and other substance use.

k. Crisis Service. Documentation of all crisis services including at a minimum:

- Date and time of service
- Presenting problem
- Services requested
- Disposition
- Staff involved (including law enforcement and other community entities, if applicable)
- Actions taken by the provider to address the problems presented
- Enrollee/ other involved parties' responses; and
- Referral to other providers (if applicable)

l. Documentation in behavioral health records of the integration of care. Documentation to include:

- Chemical dependency/abuse screening for mental health conditions and, if appropriate referral; mental health screening for chemical dependency/abuse and, if appropriate, referral.
- Screening for physical health conditions (including those which may be affecting behavioral health care and vice versa) and referral to physical health providers or primary care physician (PCP) when problems are indicated.
- Receipt of behavioral health referrals from physical medicine providers and the disposition/outcome of those referrals.
- At least quarterly (or more often if clinically indicated) for Medicaid enrollees a summary of status/progress from the behavioral health provider to the physical health provider or PCP, if provider obtained a signed release of information. Providers must document that client was offered a consent for release of information to physical health care provider if client has PCP or medical home and has an axis III diagnosis.
- A written release of information that will permit specific information sharing between providers.

m. Documentation that physical health professionals are included in a multidisciplinary approach when an Enrollee with physical disabilities or chronic or complex conditions has a co-occurring physical health disorder.

n. Behavioral Health Hospital Discharge Summaries. Discharge summaries are included as part of the medical record for: (1) all hospital admissions, which occur while the patient, is enrolled with the Contractor, and two (2) prior admissions as necessary.

o. Advance Directive. For medical records of adults, the medical record documents whether or not the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health/behavioral health care when the individual is incapacitated.

p. Behavioral Health History. Past behavioral health history is easily identified including previous mental health treatment, chemical dependency treatment, and medical conditions. (for chemical dependency specifics, see appendix 16)

q. Documentation of evidence and results of behavioral health screening.

r. Behavioral Health Assessment

- Appropriate subjective and objective information is obtained for the presenting complaints/problem.
- Assessment to include “at risk” factors (for mental health = danger to self/others, ability to care for self, affect, perceptual disorders, cognitive functioning, and significant social history; for chemical dependency/abuse = family and/or friend usage of substances, living environment, employment or legal difficulties related to substance use, and prior use/abuse,).
- Admission or initial assessment includes current support systems or lack of support systems.

s. An assessment relating to client status/symptoms to treatment process/plan is done with each visit. Documentation may indicate initial symptoms of mental health condition as decreased, increased, or unchanged during treatment period; for chemical dependency/abuse, documentation may indicate usage as absent or present. Document all treatment provided and results of such treatment.

t. Plan of treatment includes problem list, modalities, and goals. The treatment plan must have regular updates and reviews, and include a discharge plan.

u. Documentation shall include evidence of family involvement, as appropriate, and include evidence that family and/or guardians were included in treatment and treatment planning.

v. Follow-up. Documentation concerning follow-up care, calls, or visits. Specific time to return is noted in weeks, months or as needed. Unresolved problems from previous visits are addressed in subsequent visits.

w. All other aspects of client care, including ancillary behavioral health services (e.g. health education, child and medical care for adult client with dependent children,)

C. Record Review Process.

1. The Contractor has a system (record review process) to assess the content of medical records for legibility, organization, completion and conformance to its standards; and validation of administrative/claims/encounter data.

2. The record assessment system addresses documentation of the items listed in "B" above.

D. Contractor must have written QI medical record policies and procedure which include but are not limited to:

1. Written policy to ensure that medical records and information are safeguarded against loss, destruction, or unauthorized use (confidentiality is maintained as required by law).

2. Written procedures for release of information and obtaining consent for treatment.

3. Documentation that, if used, a behavior management program is clinically reviewed and approved before an Enrollee participates in any behavioral management program that includes aversive conditioning.

4. Medical record documentation requirements.

5. Medical record review/audit validation process.